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# **FINAL REPORT: Draft**

Cambodia Trip  
November, December 2003 and February, March 2004

Phnom Var:  
The HIV Village, Chamca Bai  
Kep Municipality, Kingdom of Cambodia

by

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## **Foreword**

This document is for internal review by associates of the Centre for International Health, at the University of Toronto. It is a summary of findings related to my clinical experiences and anthropological fieldwork with people living with HIV/AIDS (PLWHA) in Cambodia.

Please see Appendix 1 for the summaries of weekly activities and Appendix 2 for a copy of my Terms of Reference.

## **Introduction**

Between November of 2003 and March of 2004, I spent close to eleven weeks working in what has now become known as the HIV village, but is referred to locally as Phnom Var. My work has been clinical and anthropological. The main goal of this arm of the CIH Cambodia project is to explore whether or not we can organize and implement an equitable and operationalized provision of HIV primary health care services within the greater umbrella of the Primary Health Care Initiative. The objectives stated in my Terms of Reference included the following:

- Obtain baseline medical information on each individual living with HIV in the HIV village, including basic assessments for co-morbid conditions and nutritional status
- Conduct key informant interviews, focus groups, and use participant observation to obtain ethnographic details relating to the following issues:
  - health seeking behaviour
  - perceptions of disease state
  - perceptions of traditional and western medicine (including ARV therapy)
  - perceptions of external international medical assistance
  - perceptions of long term consequences of disease state
  - perceived health needs: social, nutritional, medical or other
  - financial security
- Ongoing collaboration with local MoH health care workers vis a vis half day per week doing clinical work at Pong Teuk Health Centre, and time permitting, half day per week of clinical rounds at Kep Referral Hospital.
- Assist as required in other CIH programming requirements, including:
  - primary health care initiative
  - resident supervision
  - orientating other CIH associates who are incoming to the field
- Maintain weekly communication with the programme director
- Produce a final report which will include both the clinical and ethnographic information<sup>1</sup>

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<sup>1</sup> Terms of Reference, Alenia Kysela, November 2003 – March 2004 (see Appendix 1)

This work involved not only the provision of basic HIV primary health care services, but included learning about HIV in Cambodia: obtaining ethnographic information from patients, Khmer health care providers, and administrators, and reviewing the existing Cambodian health care policy that pertains to HIV/AIDS.

In the pages that follow, I will detail observations related to HIV primary health care provision in the under-resourced setting of the Kep Municipality in Cambodia. This information is based on patient encounters, and ethnographic research that used qualitative methodology: key informant interviews, participant observation, focus groups, and policy review.

### **HIV in Cambodia**

Cambodia is a country of 12.7 million people, and currently, it has one of the highest prevalence rates of HIV in Southeast Asia. Last year when I reviewed the country's primary health care policy, HIV was stated to be one of the top three priorities in the MoH's list of target health problems, the other two being Maternal Health, and Childhood Infectious Diseases.<sup>2</sup> The latest HIV/AIDS epidemiological information, according to the Continuum of Care document, states the following:

New data from the HIV Sentinel Surveillance 2002 estimates the number of adults aged 15-49 years living with HIV in Cambodia to be 157 500 (2.6%). Although this represents a stabilization of prevalence, the HIV epidemic in Cambodia is now evolving into a phase in which an increasing number of people infected with HIV will become sick and seek care. New AIDS cases in 2002 are estimated to be about 19 000 and new deaths related to HIV/AIDS about 18 000.<sup>3</sup>

These numbers are important; however, I would like to point out that the message one can read between the lines, is that as people are becoming sick, those that do not realize they have HIV, due to the latent phase of the disease, will seek care, and subsequently the number of people diagnosed will reflect this and thus, the numbers cited above are likely an underestimation. This will probably occur despite the tremendous effort by the MoH and NGOs to curb the epidemic with public health campaigns regarding HIV transmission, which up until the past 12 to 18 months, has been their primary focus. Thus, we are likely at the cusp of the crisis, meaning that things are only likely to get worse before they get better, and the time to take action is now, especially in light of the WHO's 3 x 5 challenge.

Currently the MoH is using policy documents prepared by NCHADs (National Center for HIV/AIDS, Dermatology, and STD) including the Continuum of Care, as well as the

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<sup>2</sup> Health Sector Strategic Plan 2003 – 2007, Cambodian Ministry of Health, August 2002

<sup>3</sup> Continuum of Care for People Living with HIV/AIDS, National Center for HIV/AIDS, Dermatology and STD, 2003

Strategic Plan for HIV/AIDS and STI Prevention and Care 2001- 2005 <sup>4</sup> to organize and implement HIV/AIDS health care provision. NCHADs is working as the umbrella organization for all HIV/AIDS related projects occurring in the country, both those initiated by NGOs and the MoH. And as such, it would be important for the project director to meet with the NCHADs Director, Dr. Mean Chhi Vun, so that our project is “on the radar” as explained by Dr. Julian Elliott of NCHADs. He noted that if other NGOs contacted NCHADs about HIV/AIDS work in the Kep region, NCHADs would be able to tell them that another organization is already working on it.<sup>5</sup> In addition, each province has a Provincial HIV/AIDS co-coordinator who is responsible in collaboration with the Operational Director (O.D.) to implement to policy at the level of the Referral Hospital and Health Centre. Below I have included the template cited by the Continuum of Care (CoC) document and it outlines the notion of a “Comprehensive Care” for PLWHA:

Developing comprehensive care is complex and requires careful planning, coordination, referral and monitoring. Broad based mobilization of the community and organizations working outside the health sector is needed for comprehensive care to develop and be sustained. The key health sector activities needed to develop comprehensive HIV/AIDS care are:

➤ **Clinical care**

- Diagnosis of HIV infection
- Management of opportunistic infections (OI) including TB
- Prophylaxis of opportunistic infections
- Symptomatic and palliative care
- Antiretroviral (ARV) therapy
- Universal precautions (UP) and post-exposure prophylaxis (PEP)
- Prevention of mother to child transmission (PMTCT)

➤ **Support**

- Counseling
- Psychosocial and financial support
- Support for caregivers and children affected by HIV/AIDS (CAA)
- Reduction of stigma and discrimination

➤ **Health promotion and education**

- Information and education for PLHA and their families about HIV and HIV care
- Nutrition
- Prevention of further HIV transmission and family planning <sup>6</sup>

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<sup>4</sup> Strategic Plan for HIV/AIDS and STI Prevention and Care 2001-2005, Cambodian Ministry of Health, October 2000

<sup>5</sup> Personal Communication, Julian Elliot MD, advisor with NCHADs, February 13, 2004

<sup>6</sup> Continuum of Care for People Living with HIV/AIDS, National Center for HIV/AIDS, Dermatology and STD, 2003



## HIV/AIDS in Kep Municipality

Kep region contains approximately 30, 000 people. There is one referral hospital, and three health centres. I was not able to find and specific MoH data pertaining to the HIV numbers in our region. I specifically asked Dr. Dinah (who works at the Referral Hospital in Kep), and he replied that over a 2 to 3 month time period he might see 1 or 2 people with HIV.<sup>7</sup> I think this is a gross underestimation. However, at the time of our interview, he did not have a lab to do the test.<sup>8</sup>

Currently in the Kep Municipality most of the goals outlined in the Continuum of Care policy are not being addressed, which is generally the case in most of the provinces in Cambodia: “The need for HIV/AIDS care is increasing as the number of AIDS cases grows. However access to comprehensive care is still limited, particularly in provinces.”<sup>9</sup> However, there is some movement towards reaching the key goals. Using to CoC as a framework, I will address each point separately, as they pertain to Kep Municipality.

### ➤ Clinical care

- Diagnosis of HIV infection—Dr. Dinah informed me that on the 15<sup>th</sup> of March, 2004 the lab techs from the Kep hospital will be receiving the training to do HIV tests and in late March he will be receiving training on VCCT, and so, at some point in April, the Kep Hospital will be able to offer VCCT<sup>10</sup>
- Management of opportunistic infections (OI) including TB—TB care is managed via DOTS; however, when I asked Dinah about his knowledge of OIs he replied that he had had some education two years ago in the form of a two week course on HIV in Phnom Penh, and that currently, he did not know how to diagnose or recognize common OIs other than TB<sup>11</sup>
- Prophylaxis of opportunistic infections—as above
- Symptomatic and palliative care—as above
- Antiretroviral (ARV) therapy—Dr. Dinah explained that certain hospitals in PP could give ARV therapy, but he didn’t know any of the clinical details or the names of the drugs or how much it would cost<sup>12</sup>
- Universal precautions (UP) and post-exposure prophylaxis (PEP)—limited knowledge

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<sup>7</sup> Personal Communication, Dr. Dinah, Kep Referral Hospital, March 2004

<sup>8</sup> *ibid.*

<sup>9</sup> Continuum of Care for People Living with HIV/AIDS, National Center for HIV/AIDS, Dermatology and STD, 2003

<sup>10</sup> Personal Communication, Dr. Dinah, Kep Referral Hospital, March 2004

<sup>11</sup> Personal Communication, Dr. Dinah, Kep Referral Hospital, March 2004

<sup>12</sup> *ibid.*

- Prevention of mother to child transmission (PMTCT)—Dr. Dinah knew that mother's could infect their unborn children, but he was unclear about the role of ARVs in preventing transmission<sup>13</sup>

#### ➤ **Support**

- Counseling—will be initiated with pre-test counseling as a part of VCCT in April, but currently, there are no plans for post-test counseling<sup>14</sup>
- Psychosocial and financial support—not at this time
- Support for caregivers and children affected by HIV/AIDS (CAA)—not at this time
- Reduction of stigma and discrimination—there is certainly no evidence of this transpiring. Amongst health care providers at the Referral Hospital there is a fear of acquiring HIV from treating patients who have the disease to the point that Dinah said: "They should stay out at Chamca Bai and not come to the hospital. It is dangerous for us, we could get it. Other patients complain and don't want to share rooms with them. It is better for them to stay out there. Better for them, better for us"<sup>15</sup>

#### ➤ **Health promotion and education**

- Information and education for PLHA and their families about HIV and HIV care—almost all of the people I spoke with at the HIV village had very little knowledge about their disease state, had not been told where to go to receive care, and felt that their only choice was to go to Phnom Var.<sup>16</sup> However, this does not reflect the knowledge of the local population in Kep Municipality.
- Nutrition—as above.
- Prevention of further HIV transmission and family planning—the Referral Hospital does dispense OCP, and there are ongoing public health campaigns regarding condom use, and HIV transmission.<sup>17</sup>

The template outlined by NCHADs is obviously a good one, and is based on the WHO guidelines for developing countries that are dealing with an HIV epidemic. Several regions in Cambodia are successfully mounting programs to address the above issues, including the hospitals in Phnom Penh that are running ARV programs. Notably the

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<sup>13</sup> *ibid.*

<sup>14</sup> *ibid.*

<sup>15</sup> *ibid.*

<sup>16</sup> Fieldnotes 2003-2004

<sup>17</sup> *ibid.*

MSF initiatives in Siem Reap and Takeo model their programs such that ‘comprehensive care’ is the goal.<sup>18</sup>

### **MSF Siem Reap: Chronic Diseases Clinic**

In December I spent three days working with the MSF Siem Reap ARV treatment project. It operates both inside and outside of the MoH. Logistically the project is located within the Referral Hospital and they hire Khmer doctors and support staff to work alongside the international team. This works to ‘build capacity’ by training the Khmer health care providers, while at the same time ensuring that international standards of care are being met, meaning equitable access to HIV/AIDS treatment. This works to reduce stigma via formal education, and by example. Also, they call their clinics “Chronic Disease Clinics” and treat hypertension and diabetes in addition to HIV, thus reducing the public stigma by treating people with a variety of chronic health problems at the same clinic.<sup>19</sup>

### **Phnom Var**

#### **Population Demographics**

All people who are referred to as HIV positive reported having received a positive test either through VCCT or at a hospital. Those who are reported as being HIV negative gave the history of having a negative test. Patients listed as unknown had not ever been tested, but had risk factors for HIV infection.

The people who are living at the HIV village, otherwise known as Phnom Var,<sup>20</sup> are from all over Cambodia, and have decided to leave their home communities (see Table 1) to receive treatment from the Kru Khmer (traditional healer), Lok Boe.

Table 1: Distribution of Home Communities

	HIV+ Female	HIV+ Male	HIV- Female	HIV- Male	HIV?Female
Battambang	2	2	1		
BanteyMeanchey		1			
Kaokout		1			
KampongChnang		3	2		
Kampongsong	1	1			
Kampong Speu	1		1		
KampongTrach	1	1			
Kampot	1	3	1		1
Kep			3	1	
Phnom Penh	5	4	2	1	
Sihanoukville		2			

<sup>18</sup> Personal Communication Deres Brooke, Head of Mission MSF Belgium, Siem Reap HIV/AIDS Project, December 2003

<sup>19</sup> *ibid.*

<sup>20</sup> Personal Communication with patients and Kru Khmer, March 2004

Svay Rieng	2	2			
Takeo	3	3	2		1
Unknown				1	
TOTAL	16	23	12	3	2

The population of the village varies. In March of 2003, there were an estimated 300 people living at Phnom Var.<sup>21</sup> I understood from Ian Small and Bunthoeun that in July and August of 2003, there were approximately 100 people at the village.<sup>22</sup> We tracked population variances by doing door to door surveys every two to three weeks, where BT would count members of families, and list their home community: in Nov. and Dec. 2003 there were between 60 and 80, and as of early March 2004, there were 21 families, and approximately 25 to 30 people with HIV, with a total of 45 people living at the village. During my entire time working at the village, I saw 56 different patients. The ages ranged from 1.5 years to 72 years (see Table 2).

Table 2: Age Distribution of Patients seen at Phnom Var

	HIV+ Female	HIV+ Male	HIV- Female	HIV-Male	HIV?Female
<5 years				1	
5 to 10 years			2	1	
11 to 20 years			1		
21 to 25 years	2	3	1		
26 to 30 years	2				
31 to 35 years	7	7			2
36 to 40 years	4	8	1		
41 to 45 years		2	1		
46 to 50 years	1	1	1		
51 to 55 years		1	2		
56 to 60 years		1	3		
> 60 years				1	
TOTAL	16	23	12	3	2

<sup>21</sup> Fieldnotes, Cambodia Trip February/March 2003—Personal Communication with Lok Boe

<sup>22</sup> Ian Small, Personal Communication

People go to Phnom Var as families or as individuals, usually with one or two family members who will care give. People come and go from the village for a variety of reasons. Sometimes they return to their 'homeland' to try to raise money to support their stay at Phnom Var, either through working at their previous job (see Table 3), or to ask extended family members for money. People also leave to look after children, or to arrange alternative living plans for their children, recognizing that once they die, the children will be homeless. Still others start to feel well, and leave to resume some semblance of 'normal' life.<sup>23</sup> This is of course problematic because once they run out of their OI prophylactic/treatment meds, they will start to feel unwell again.

Table 3: Occupations of Inhabitants of Phnom Var, prior to moving from home community

	HIV+ Female	HIV+ Male	HIV- Female	HIV- Male	HIV?Female
Café Worker	1				
Car/Taxi Driver		1			
Cook in Rest.	1				
CHILD			4	2	
Dentist		1			
Electrician		1			
Farmer	4	3	4		2
Fisherperson	1	3			
GarmentFactory	1		1		
Housekeeper	2				
Housewife	2		2		
Military Soldier		5			
Monk				1	
Seller	4	6	1		
RamorqueDriver		1			
Unemployed		1			
Unknown		1			
TOTAL	16	23	12	3	2

### Clinical Encounters

I had a total of 215 clinical encounters with people living at Phnom Var; the length of time per encounter ranged from 15 minutes to 90 minutes.

Initial encounters included a complete history and physical exam, as well as listening to individual's narratives regarding their experience living with HIV. Generally speaking most people had a poor understanding of the effects of HIV on the body, and more specifically on the immune system. A large part of the initial consultation was spent

<sup>23</sup> Fieldnotes Phnom Var 2003 - 2004

doing patient education regarding natural history of HIV/AIDS and in explaining the nature of opportunistic infections. Finally, I would outline the types of treatments that I could provide. Usually I would introduce the idea of ARVs at this juncture and would obtain information regarding people's perceptions regarding their treatment options.

I used the WHO clinical staging system for HIV infection and disease:

Clinical Stage 1:

- Asymptomatic
- Persistent generalized lymphadenopathy (PGL)

Clinical Stage 2:

- Weight loss <10% of body weight
- Minor mucocutaneous lesions (seborrheic dermatitis, prurigo, fungal nail infections, recurrent oral ulcerations, angular cheilitis)
- Zoster within the last five years
- Recurrent URTI (incl. bacteria sinusitis)

Clinical Stage 3:

- Weight loss >10% of body weight
- Unexplained chronic diarrhea for > 1 month
- Unexplained prolonged fever (intermittent/constant) for > 1 month
- Oral candidiasis (thrush)
- Oral hairy leukoplakia
- Pulmonary tuberculosis within the past year
- Severe bacterial infections (pneumonia, pyomyositis)

Clinical Stage 4:

- HIV wasting syndrome
- Pneumocystis carinii pneumonia (PCP)
- Toxoplasmosis of the brain
- Cryptosporidiosis with diarrhea, for > 1 month
- Cryptosporidiosis, extrapulmonary
- Cytomegalovirus (CMV) disease of an organ other than liver, spleen, or lymph nodes
- Herpesvirus infection, mucocutaneous for > 1 month, or visceral of any duration
- Progressive multifocal leukoencephalopathy (PML)
- Any disseminated endemic mycosis
- Candidiasis of the esophagus, trachea, bronchi, or lungs
- Atypical mycobacteriosis, disseminated
- Nontyphoid salmonella septicemia
- Extrapulmonary tuberculosis
- Lymphoma
- Kaposi sarcoma
- HIV encephalopathy



- Invasive cervical cancer<sup>24</sup>

This is a *clinical* staging system, meaning it is based on conclusions derived from history and physical examinations. Thus, any assessments of co-morbidities, or HIV related Opportunistic Infections were based on clinical acumen, and in fact, are clinical suppositions, meaning they are not substantiated by serologic or radiological investigations. Therefore, I am not going to cite numbers related to OIs for instance, since I cannot say factually that individuals had particular infections, I can only state how many people were deemed to be WHO 1, 2, 3, or 4, and from there, we can surmise how many may have had particular OIs.

Table 4: WHO HIV Clinical Staging of Patients at Phnom Var

	WHO 1	WHO 2	WHO 3	WHO 4
HIV + Female	1	6	5	4
HIV + Male	2	4	12	5
TOTAL	3	10	17	9

Table 5: Number of Clinical Encounters by WHO HIV Clinical Staging

	WHO 1	WHO 2	WHO 3	WHO 4
HIV + Female	6	18	15	34
HIV + Male	4	9	51	41
TOTAL	10	27	66	75

Table 6: Average Number of Clinical Encounters per patient by WHO HIV Clinical Staging

	WHO 1	WHO 2	WHO 3	WHO 4
HIV + Female	6	3	3	8.5
HIV + Male	2	2.25	4.25	8.2

Table 7: Number of Deaths per WHO HIV Clinical Staging

	WHO 1	WHO 2	WHO 3	WHO 4
HIV + Female	-	-	1	3
HIV + Male	-	-	-	3
TOTAL	-	-	1	6

NB. One female patient died as a consequence of suicide by hanging.

<sup>24</sup> Oxford Handbook of Tropical Medicine, 2002, Oxford University Press, Oxford, England p. 52 - 53



Top Three Presenting Complaints for HIV+ Men:

- cough
- diarrhea
- insomnia/fatigue

Top Three Presenting Complaints for HIV+ Women:

- cough
- diarrhea
- insomnia/fatigue/headache

Top Three Diagnoses for HIV+ Men:

- Respiratory Tract Infection:
  - TB
  - OI
- Gastroenteritis—Diarrhea with none to severe dehydration:
  - OI
- Situational Crisis:
  - grief—diagnosis, loss of employment, financial, death of a loved one, effects of disease on children and other family members, loss of material goods: home

Top Three Diagnoses for HIV+ Women:

- Respiratory Tract Infection:
  - TB
  - OI
- Gastroenteritis—Diarrhea with none to severe dehydration:
  - OI
- Situational Crisis:
  - caregiver stress
  - grief—diagnosis, loss of employment, financial, death of a loved one, effects of disease on children and other family members, loss of material goods: home

Clinical Encounters with HIV negative Population:

- *3 males*
  - 5 encounters
  - mean of 1.67 visits per patient
  - diagnoses:
    - RTI x 2
    - diarrhea x 1
    - a. fib. x 1
- *12 females*
  - 32 encounters
  - mean of 2.67 visits per patient

- diagnoses:
  - RTI x 5
  - HTN
  - Trauma
  - OA x 2
  - Dental Caries/Gingivitis x 1
  - Breast Ca with probable mets x 1
  - Caregiver Stress x 2
  - Conjunctivitis x 1
  - GERD x 1

Clinical Encounters with HIV Status Unknown Population:

- 2 females
  - 6 encounters
  - mean of 3 visits per patient
  - diagnoses:
    - RTI x 1
    - folliculitis x 1
    - caregiver stress x 1

Table 8: Perceptions of Disease Acquisition

	Intercourse with Husband No Condom	Intercourse with Wife No Condom	Intercourse with Sex-Trade Worker No Condom	Unknown
HIV + Females	15			1
HIV + Males		2	18	3

NB. Unknown: the four who didn't know how they had acquired HIV denied using IV drugs, having a blood transfusion and having intercourse without a condom with a sex-trade worker or their spouse.

Intercourse with Wife No Condom: one patient believed his wife had acquired HIV from her first husband, and the second believed his wife had acquired HIV from getting blood on herself during a taxi/moto accident.

Tuberculosis and Phnom Var:

When people arrive at Phnom Var, Lok Boe tells them that all people with HIV have TB, and so, when asking people their history regarding TB it became important to discern between a diagnosis that was given by Lok Boe, and whether or not they had a TB test or CXR confirmed diagnosis. I advised all patients to go to the Referral Hospital in Kep for evaluation and treatment of TB, as well as educating them about HIV and TB co-infection. Of the 39 HIV+ individuals, only 4 had had any formal TB testing or treatment:

	TB+ on CXR < 6 mos.	TB- on CXR < 6 mos.	TB+ with RX < 5 yrs.
HIV+ Pop. Phnom Var	1	1	2

All of the HIV+ patients at Phnom Var had at some point been taking TB meds supplied by Lok Boe for a fee of \$ 4 -5/month. He would give them Ethambutol, Rifampin, and Vitamin B6 in unknown doses, to be taken once a day.

### Nutritional Status of Phnom Var Population:

Generally speaking, the HIV+ population of Phnom Var was undernourished. However, this is not simply a consequence of lack of food, but points more to the nature of HIV disease, meaning that part of the disease state is wasting, and it is not amenable to caloric supplementation.<sup>25</sup> I did obtain baseline weights and heights for the patients, but I have yet to calculate BMIs. However, using the WHO HIV clinical staging as a means of determining the number of people who had sustained a weight loss of >10% of their body weight (WHO 3), there were 17 patients in this category; and, WHO stage 4 necessarily implies having Wasting Syndrome, and that would include 9 patients. Thus, 66% of the HIV + population at Phnom Var were underweight.

Buntheun conducted a nutritional survey on November 27, 2003 as a means of determining what food was needed most by the population. This was conducted in part to assess what food items the CIH could supplement to Phnom Var. BT surveyed the entire village, 29 households, and asked two questions:

- What did you eat at supper last night, and at breakfast this morning?

	Rice	Meat	Fruits	Vegetables
Supper	19	18	6	12
Breakfast	16	18	5	5

- During the last month, what food did you need the most but didn't have?

	Rice	Meat	Fruits	Vegetables
# of Households	29	27	22	26

This survey was meant to take a simple look at what people were eating, and to arrive at an understanding of people's basic nutritional needs. From these numbers, we decided to supplement the village with rice and dried fish, both of which keep well and go along with what people outlined as being the most needed. Obviously, one can also conclude that there was a deficiency of fruits and vegetables from their diets, however, BT explained to me that rice is central to all three meals, and that fruits and vegetables are

<sup>25</sup> "Caloric Supplements alone do not increase weight in AIDS patients" J. AIDS, 22:253, 1999

less expensive, and so, if we provided the rice and meat, people could purchase fruits and vegetables on their own.

### *Traditional Medicine and Financial Burden of Living in Phnom Var*

Lok Boe, the Kru Khmer, or traditional healer at Phnom Var, had a dream that he could cure HIV/AIDS by making a tea from a medicinal plant from the jungle. He opened Phnom Var in January of 2002, and placed advertisements in magazines stating his purpose. He will not reveal the ingredients of the tea. Most people who come to Phnom Var take between 1 and 4 kettles of tea per day. The cost is 4000 Riel per kettle, which is approximately \$1 USD. Thus, on average, a patient might spend between \$1 and \$4 USD per day on the tea.

Lok Boe, usually has people stay for a 6 to 9 month time period, and he doesn't formally ask people to leave, but it seems as though there is an unwritten rule that once that time period has elapsed, people should leave. Families pay him rent of \$30 per time period to live in a house on his land; these houses constitute the village. There are 46 individual houses which either stand alone or are contiguous with one another, meaning they share one or more walls.<sup>26</sup>

Although the majority of the people living in Phnom Var have occupations, they are not actively earning money while living here, either because they are too sick, or they face discrimination from the local populous of Chamca Bai.<sup>27</sup>

### *Phnom Var: Community as Cure*

Although the people who are living at Phnom Var are there under the auspices of receiving care from a Kru Khmer, they are also there because it has become known as a community for PLWHA. The people who are living there help each other simply by being a congregation. Most people hear about Phnom Var from neighbours or relatives or from reading a magazine advertisement.<sup>28</sup> The option to go to a geographical enclave where other people dealing with HIV either as an individual infected, or as a care giver, is one which is enticing, particularly in the face of discrimination amongst Cambodian people with regards to HIV/AIDs.

The women who are care giving to sick husbands often sit and share their burdens with each other. The men and women socialize in customary Khmer ways: playing cards, cooking, talking, children playing.<sup>29</sup> If individuals do not have money to buy food, other community members will find food for them. If an individual arrives alone, the rest of the people will come together to sit with that person, or be with them while they are dying, and will ensure an appropriate funeral rite is provided.<sup>30</sup> And so, the benefit of

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<sup>26</sup> Survey of Phnom Var, November 2003, Buntheun Thon

<sup>27</sup> Fieldnotes Phnom Var, 2003-2004

<sup>28</sup> *ibid.*

<sup>29</sup> *ibid.*

<sup>30</sup> *ibid.*

simply coming together to live within a safe space, meaning a village whereby people can live and not be afraid of discrimination, and can find support and comfort from others who are experiencing a similar struggle, cannot be underestimated. Of course, there is a price paid. They have left behind all that previously had meaning for them: job, house/home, family, friends etc.... Yet despite these costs, people do choose to go to Phnom Var because they believe they have no other option, and because of the benefits of 'community' which I described above.<sup>31</sup>

### Perceptions of disease state, health related needs and Western Medicine:

When asked what it meant to have HIV, people spoke of a sickness that makes the body tired, that 'eats away substance'. All of the people with HIV at Phnom Var knew that HIV disease leads to death; however, most were misinformed as to the length of time to death from the onset of symptoms. Most people believed that the formal health care infrastructure could not help them, and that taking Lok Boe's tea would prolong their life.<sup>32</sup> However, when I explained to them the nature of the care I would be providing, they were eager to present with their symptomatology. Many asked if they could continue to use Lok Boe's tea, and I encouraged them to make their own decisions and explained that it would not bother me, but that I could not guarantee that there would not be an interaction between the Western medications and the tea. Nevertheless, a pluralistic approach was the one I took.

All patients desired to have their concerns met with some sort of treatment. Cambodian medical culture places great value on the active, meaning that pills and IV infusions signify an act of curing. For example, I explained that I would not be providing IV fluids, and instead tried to frame ORS as being similar to IV fluids in constituency, and that the mode of delivery was the only real difference. Another illustration of this included ensuring that individuals who were WHO 1 and essentially asymptomatic had a good supply of acetaminophen; this went a long way along with a listening ear. Additionally, those that had bona fide diagnoses, like oral candidiasis, were extremely pleased to see their physical manifestations of disease disappear with appropriate treatment. Further, as noted above, many people had grief issues that they wanted to talk about. Often 15 or 20 minutes of an encounter would be spent in normalizing their experience of loss, sadness and fear.

The people at Phnom Var, including Lok Boe, are happy that the CIH is providing basic HIV primary health care services. Of course, Boe has a vested interest in our presence in that it substantiates his own endeavours merely by our being in the village; this occurs despite any clear formal distance we might put forth regarding our approaches to therapy. Regardless, I think that what has been important about our ongoing involvement with the people of Phnom Var is that in giving people the choice to come to clinic at the village, and in educating them about their disease while at the same time offering what treatment we can, we have succeeded in increasing individual's agency with respect to their positions as people living with HIV in Cambodia. Their only concern was why we

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<sup>31</sup> *ibid.*

<sup>32</sup> *ibid.*

weren't treating TB.<sup>33</sup> I generally responded to this question by advising them to go to the Referral Hospital to be tested and if need be, to participate in DOTS. Also, once they became educated about the potential benefit of ARV therapy, they were eager to know when that might be available. Again, I would refer them to the known ARV treatment programs in Cambodia.

### Health Seeking Behaviour and Choices:

Cambodia exists in what can be conceptualized as a 'culture of silence'. As a consequence of civil war and the after effects of surviving genocide, the Cambodian people are hesitant and even somewhat resistant to accessing and utilizing the existing health care infrastructure. This is in part related to the historical destruction of the health care system during the Pol Pot regime, and thus, inherently people view it as being 'broken'.<sup>34</sup> And what has carried over from thirty years of civil unrest, is an inherent distrust of formal government organizations, such as the Ministry of Health. Furthermore, since the country has become inundated with external agencies working within the health care sector, people have come to signify external aid agencies with 'good care' and internal health infrastructure as 'bad care' or 'broken', as I mentioned above. Although people do not come forth with this notion explicitly, there is a perception that care from health centres or referral hospitals is not going to result in a dissipation of symptoms, or even a cure.<sup>35</sup> Thus, people have become 'silent' with regards to their health concerns and choose to seek care for their illnesses either from traditional healers or from pharmacists.<sup>36</sup> For example, of the 39 patients with HIV at Phnom Var, four of them had previous knowledge of HIV treatment centres (Takeo x 2, Phnom Penh x 2), and they chose not to attend for fear of dying or simply in the belief that there cannot be a treatment for their disease.<sup>37</sup>

Prior to my arrival, the people living at Phnom Var had limited knowledge of their options related to HIV health care service delivery. Although I explained to each patient the nature of ARV treatment and where they could locate treatment programs, none chose to pursue this avenue. Largely I think this is due to the aforementioned reasons and also is a consequence of the 'community effect' of Phnom Var. Furthermore, a lack of funds to secure appropriate living space either in Phnom Penh, Siem Reap or Takeo probably contributes to people's hesitation in moving to one of those regions.

### Future Directions

It would be practically impossible to mount a comprehensive care program for PLWHA at the Phnom Var village at this time. Although the village now has a generator, thanks to a donation in December 2003 from Aspeca, the French NGO which runs the orphanage

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<sup>33</sup> *ibid.*

<sup>34</sup> Fieldnotes: Phnom Var 2003 - 2004

<sup>35</sup> *ibid.*

<sup>36</sup> *ibid.*

<sup>37</sup> *ibid.*



in Kep, the logistical requirements of lab, x-ray, inpatient ward etc... are too great for the physical site. Furthermore, operating such a project on site at Phnom Var, would seem to be in contravention with our overall goal of operating within the MoH. So, my suggestion is that we work towards a model similar to that of MSF, and start an “HIV Primary Health Care Centre of Excellence” at the Referral Hospital. This idea stems from two days of conversation with James Orbinski in early February and is based on Ian Small’s overall vision for a CIH Primary Health Care Centre of Excellence.

The ‘Centre’ would necessarily include HIV ‘comprehensive care’, maternal health care, and in the future could involve childhood pediatric diseases. And, in addition to having outpatient clinics, we would have the use of inpatient hospital beds. (In the rest of this paragraph I will only be discussing the HIV related issues.) This way we can have access to appropriate investigational tools: x-ray, lab etc..., we can work towards ‘building capacity’ with the health care providers by teaching them about HIV care, and not only would we be serving the Phnom Var population, but we would be reaching the general population of our catchment area. Part of the plan would have to include providing transportation for people from Phnom Var to the hospital, which likely would only be required once or twice a week, and could include ongoing itinerant visits to the village on a twice monthly basis to ensure continuity.

We are at the cusp of the crisis regarding HIV in Cambodia, and over the next several years, the illness burden will start to declare itself. Now is the time to get this going, so that we can appropriately work with our counterparts and help them deal with this public health concern. In addition, we can establish ourselves as a ‘Centre of Excellence’ and become a regional referral centre. As we know, Kampot Province is a disaster as far as health NGOs go,<sup>38</sup> and feasibly we could become the HIV/AIDS Primary Care Program for Kampot Province—which has a population of 529 655<sup>39</sup>--in addition to servicing the Kep Municipality. This initiative would fit with the MoH’s HIV policy, and meet our own institutional goals of working within the MoH infrastructure.

As I noted above, steps are being taken to implement the policy (VCCT at the Kep Hospital), and now is the time to help them along, right at the beginning. In addition, we would be working towards the WHO’s 3 x 5 goal. The CIH has had a strong working relationship with the OD, MoH, NCHP for well over a year, and since we have this foundation, I think this idea would be well received. Furthermore, we can address Maternal Health through this plan, by working on HIV testing in pregnancy, and could set up an antenatal clinic as part of the “Primary Health Care Centre of Excellence”. Finally, this plan would encompass all three of the main areas identified by the MoH as most needing attention: HIV/AIDS, Maternal Health, and eventually, Pediatric Infectious Diseases.<sup>40</sup>

I think this idea is preferable to the UCC plan because it does involve physically locating within the MoH Referral Hospital and this way ensures that we will be working with

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<sup>38</sup> Personal Communication Ian Small, Fieldnotes Cambodia, November 2003

<sup>39</sup> Health Coverage Plan—MoH: Department of Planning and Health Information, June 2002

<sup>40</sup> Health Sector Strategic Plan 2003 – 2007, Cambodian Ministry of Health, August 2002



local counterparts to 'build capacity'. Furthermore, as outlined in detail in the Continuum of Care, our project would have to include psychosocial health concerns, and thus would address the issue of rehabbing people to go back into their communities once they are stabilized on ARVs, and eventually they could return to Kep for once monthly check-ups, as necessary. Again, this is what happens at the MSF SR project.<sup>41</sup>

### **Issues Requiring Attention:**

#### **Transportation:**

I used a moto during my time in Cambodia, with Buntheun as the driver, however this was not the safest method of transportation, and necessarily we had to hire taxis to go to and from Phnom Penh. In addition, when the team is larger than one, a vehicle does become necessary, and we did have to rent a truck on more than one occasion.

Recommendation: CIH needs to purchase a vehicle for use by the Primary Health Care Initiative team in Cambodia.

#### **Patient Record System:**

I kept notes on all patients seen, using the SOAP method of recording patient information. There was no mention in my ToR, nor is there existing CIH policy on the issue of patient records.

Recommendation: Form a committee to examine this issue, review other agencies policy, outline policy for the CIH, and work towards implementation of a standard patient charting system that can remain in Cambodia.

#### **Handover Between Team Members:**

To my knowledge, there currently isn't any CIH policy regarding this issue. The basic way this was undertaken between Dr. S. Grewal, Ann Luvold and myself, was that I had outlined relevant issues relating to logistics, programming, local geography and medical/patient issues, and I addressed each of these areas with Ann and Shiv, in addition to answering as I could, their many questions.

Recommendation: Form a committee to examine this issue, and determine appropriate issues to be covered as well as formal patient handover guidelines.

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<sup>41</sup> Personal Communication Deres Brooke, Head of Mission MSF Belgium, Siem Reap HIV/AIDS Project, December 2003

## APPENDIX 1

### WEEKLY SUMMARIES

*November and December 2003*

#### Week #1, November 10<sup>th</sup> - 16<sup>th</sup>

Monday 10<sup>th</sup>:

- arrive PP

Tuesday 11<sup>th</sup>:

- lunch with Chris Turner: CIDA Canada Fund
- interview medical students from PP Medical School re—translation
  - five students
  - decided on Sokun
- BT and A
  - drug inventory
  - purchase office supplies, drugs, helmet

Wednesday 12<sup>th</sup>:

- attend ROSE & Grapes of Wrath donation ceremony with Dr. M. Beveridge, Dr. J. Gollogly
- bank with Ian to set up account
- drive to Kep in afternoon

Thursday 13<sup>th</sup>:

- 9am meeting with Men Sothay—Operational Director, Kep, Municipality, and Ian Small
  - discussed MoU, HIV village project, longterm goals of primary health care initiative (please contact me for meeting notes if required)
  - Men Sothay signed and took copy of letter from the MoH outlining Dr. A. Kysela's clinical and evaluation & monitoring work at Phnom Var
- Meeting with Lok Boe traditional healer at Phnom Var
- discussed clinical treatment:
  - no ARVs
  - no TB meds
  - basic clinical assessment and treatment of OIs
  - discussed 'ethnography':
    - working to understand people's perception of health and illness, perceived understandings of access to health care, and impact of disease state on their everyday lives
  - Lok Boe was enthusiastic about the project, and we agreed to hold a 'village meeting' to discuss the goals of information gathering, meaning hearing their 'stories', as well as providing clinical services

- meeting set for Monday the 17<sup>th</sup>
- Visited local guesthouses, decided to move to Veranda Guesthouse for length of stay; to move on the 14<sup>th</sup>
- Ian negotiated clinic construction

Friday 14<sup>th</sup>:

- Ian met with counterparts from the NCHP, and Men Sothay; I attended
  - discussed liaison between three institutions: NCHP, MoH—Kep, U of T
- lunch with counterparts
- moved to new guesthouse

Saturday 15<sup>th</sup>:

- free day
- to Kampot for food supplies

Sunday 16<sup>th</sup>:

- Sokun arrives: orientation regarding translation
- met with Ian from 2 – 4pm regarding logistical and programmatic issues

Week #2, November 17<sup>th</sup> to 23<sup>rd</sup>:

Monday 17<sup>th</sup>:

- Village meeting at Phnom Var:
  - ~40 people attended
    - discussed clinical treatment, fielded questions, explained my interest in understanding their perceptions regarding HIV, in hearing their ‘stories’
- clinic construction almost completed
- to UCC with Ian, BT to look at premises
- Met with Ian to discuss and finalize ToR
- Ian and BT finalized his ToR, contract
- Ian explained financial issues
  - BT’s salary
  - Sokun’s salary
- Met with the Governor of Kep Region
  - Ian explained CIH’s initiative

Tuesday 18<sup>th</sup>:

- Phnom Var Clinics:
  - 8:30 – 12:00: hut visits to sickest
  - 12:30 – 3pm: clinic

Wednesday 19<sup>th</sup>:

- Pong Teuk Health Centre:

- 8am to 10am—saw consults with Health Centre staff, discussed difficult cases
- Clinic at Phnom Var—10:30am to 1:30pm
- Met Chamca Bai village chief
  - discussed as above
  - thanked him for having us work with the people in his region
- Afternoon in Kampot for medical supplies

Thursday 20<sup>th</sup>:

- Clinic at Phnom Var:
  - 8am to noon—hut visits to sickest
  - 12:30pm to 4:30pm—ambulatory care clinic

Friday 21<sup>st</sup>:

- Clinic at Phnom Var:
  - 8:30am to noon—hut visits to sickest
- Drive to Phnom Penh

Saturday 22<sup>nd</sup>:

- free day

Sunday 23<sup>rd</sup>:

- supplies: pharmacy, meds containers etc...
- drive to Kep

Week #3, November 24<sup>th</sup> to 30<sup>th</sup>:

Monday 24<sup>th</sup>:

- Clinic at Phnom Var:
  - 8am to noon—hut visits to sickest
  - 12:30pm to 4:00pm—ambulatory care clinic
- Phone call to Ian for update

Tuesday 25<sup>th</sup>:

- 9am meeting with Men Sothay, Operational Director, bi-weekly update and drop off document from Ian to DHO
- Clinic at Phnom Var:
  - 9:30am to noon—hut visits to sickest
  - 12:30pm to 3:30pm—ambulatory care clinic

Wednesday 26<sup>th</sup>:

- Pong Teuk: no clinic because at vac. outreach
- Clinic at Phnom Var:
  - 8am to noon—hut visits to sickest

- Kampot in afternoon for supplies
- contacted Sarath in Siem Reap, Provincial AIDS Director, set up appmt for next week
- contacted MSF Siem Reap, established connection, set up visit for next week

Thursday 27<sup>th</sup>:

- Clinic at Phnom Var:
  - 8am to noon—hut visits to sickest
  - 12:30pm to 3:30pm—ambulatory care clinic
- BT did brief nutritional survey regarding food needs
- phone calls to Stefanie Beck, NCHP

Friday 28<sup>th</sup>:

- Clinic at Phnom Var:
  - 8am to noon—hut visits to sickest
  - 12:30pm to 4:00pm—ambulatory care clinic
- Phone calls to Chea Sokim regarding MoU

Saturday 29<sup>th</sup>:

- Clinic at Phnom Var:
  - 8am to noon—hut visits to sickest
- to PP

Sunday 30<sup>th</sup>:

- weekly bookkeeping

Week #4, December 1<sup>st</sup> to 7<sup>th</sup>:

Monday 1<sup>st</sup>:

- pick up tickets for SR
- took MoU letter of support to Chea Sokim
- meet with Stefanie Beck, Canadian Ambassador
  - discussed work at Phnom Var
  - obtained contacts from Stephanie regarding other Canadians working with PLWHA
- fly to SR with BT

Tuesday 2<sup>nd</sup>:

- MSF HIV/AIDS initiative in Siem Reap
  - attended ceremony with Governor, Sarath, MSF staff 8am to 12noon
  - tour of facilities
  - lunch with MSF staff
  - attended clinic 2 to 5pm

Wednesday 3<sup>rd</sup>:

- 9am meeting with Sarath, Provincial AIDS Co-ordinator—he spoke at the Munk Centre in November, which I attended, and had met him at that time
- 10:30am meeting with head of MSF Siem Reap Mission
  - discussed programmatic issues
    - capacity building
    - working within Ref. Hospital as working within MoH
- back to PP in afternoon

Thursday 4<sup>th</sup>:

- pharmacy in am, market for pill containers
- NCHP to find letter of support from Chea Sokim
- to Kep in afternoon

Friday 5<sup>th</sup>:

- Clinic at Phnom Var:
  - 8am to noon—hut visits to sickest
  - 12:30pm to 3:30pm—ambulatory care clinic
- Meeting with Lok Boe:
  - he is pleased with the CIH involvement at the village
  - he asked if we would provide IV meds, and TB meds, which I explained that we would not be at this time

Saturday 6<sup>th</sup>:

- Clinic at Phnom Var:
  - 8am to noon—ambulatory care clinic

Sunday 7<sup>th</sup>:

- free day
- bookkeeping

Week #5, December 8<sup>th</sup> to 14<sup>th</sup>:

Monday 8<sup>th</sup>:

- Clinic at Phnom Var:
  - 8:30am to noon—hut visits to sickest
  - sick in pm

Tuesday 9<sup>th</sup>:

- sick day
- BT to Kampot to rent vehicle due to safety concerns using motos

Wednesday 10<sup>th</sup>:

- 8am to 9am: Pong Teuk
- Clinic at Phnom Var:

- 9:30am to noon—hut visits to sickest
- 12:30pm to 3:30pm—ambulatory care clinic

Thursday 11<sup>th</sup>:

- Clinic at Phnom Var:
  - 8am to noon—hut visits to sickest
  - 12:30pm to 4:00pm—ambulatory care clinic

Friday 12<sup>th</sup>:

- Clinic at Phnom Var:
  - 8am to noon—ambulatory care clinic
- to PP in afternoon

Saturday 13<sup>th</sup>:

- free day
- phone call to Ian update

Sunday 14<sup>th</sup>:

- pharmacy, supplies
- BT to market to purchase food for Phnom Var
- bookkeeping

Week #6, December 15<sup>th</sup> to 21<sup>st</sup>:

Monday 15<sup>th</sup>:

- bank
- back to Kep

Tuesday 16<sup>th</sup>:

- Clinic at Phnom Var:
  - 8:30am to noon—hut visits to sickest
  - 12:30pm to 3:30pm—ambulatory care clinic

Wednesday 17<sup>th</sup>:

- Pong Teuk staff at training, therefore no clinic
- Clinic at Phnom Var:
  - 8:30am to noon—hut visits to sickest
  - 12:30pm to 3:30pm—ambulatory care clinic

Thursday 18<sup>th</sup>:

- 9am Meeting with Men Sothay, which he did not show up for
- made Veranda bookings for Ed Vreekes, Patrick Skalenda
- Clinic at Phnom Var:
  - 9:30am to noon—ambulatory care clinic
- to PP in afternoon



Friday 19<sup>th</sup>:

- Meeting with Chea Sokim
  - explained that he was to give me MoU so that I could bring it to Canada
  - he explained that he would not do that until next meeting with Ian and/or David
  - said he needed specifics regarding project costs and time commitment
  - he said he still didn't have email despite Ian having given him a modem
- made Oasis bookings for Ed Vreekes, Patrick Skalenda
- afternoon at Medicam

Saturday 20<sup>th</sup>:

- bookkeeping
- free day

Sunday 21<sup>st</sup>:

- free day

Week #7, December 22<sup>nd</sup> to 28<sup>th</sup>:

- off

December 29<sup>th</sup>, back to Canada

*February and March 2004*

Week#1, February 2<sup>nd</sup> to 8<sup>th</sup>:

Monday 2<sup>nd</sup>:

- depart Canada

Tuesday 3<sup>rd</sup>:

- arrive PP, Cambodia

Wednesday 4<sup>th</sup>:

- 7:30am breakfast meeting with James Orbinski, Patrick Skalenda
  - discussed Phnom Var: ethics, pragmatics of HIV primary health care in Cambodia
  - Patrick outlined his impressions regarding the KAP of health care workers and primary health care policy
- bank
- computer store
- pharmacy
- supper meeting with James and Patrick

Thursday 5<sup>th</sup>:

- attended meeting with James Orbinski, Patrick Skalenda
  - UNAIDS
    - head of UNAIDS Cambodia: Geeta Setha, outlined the current situation regarding HIV initiatives in Cambodia
    - discussed useful contacts re-HIV in Cambodia
- to Kep in afternoon

Friday 6<sup>th</sup>:

- Clinic at Phnom Var:
  - 9am to noon—hut visits to sickest
  - 12:30pm to 3:00pm—ambulatory care clinic

Saturday 7<sup>th</sup>:

- Clinic at Phnom Var:
  - 9am to noon—ambulatory care clinic

Sunday 8<sup>th</sup>:

- free day
- bookkeeping

Week #2, February 9<sup>th</sup> to 15<sup>th</sup>:

Monday 9<sup>th</sup>:

- Clinic at Phnom Var:
  - 8am to 9am: meeting with Lok Boe
    - update on population of Phnom Var, discussed many people having left, some who have died
  - 9am to noon—hut visits to sickest
  - 12:30pm to 3:00pm—ambulatory care clinic
- Contact Julian Elliot at NCHADs to arrange meeting
- Contact Marie Ens, Canadian woman running NGO for HIV orphans, to set up visit date

Tuesday 10<sup>th</sup>:

- Clinic at Phnom Var:
  - 8:30am to noon—hut visits to sickest
  - 12:30pm to 3:00pm—ambulatory care clinic

Wednesday 11<sup>th</sup>:

- Clinic at Phnom Var:
  - 8:30am to noon—hut visits to sickest
  - 12:30pm to 3:00pm—ambulatory care clinic

Thursday 12<sup>th</sup>:

- Clinic at Phnom Var:

- 8:30am to noon—ambulatory care clinic
- to Phnom Penh in afternoon

Friday 13<sup>th</sup>:

- 8am meeting with Julian Elliott of NCHADS:
  - discussed CIH Cambodian Primary Health Care Initiative
    - HIV primary health care in Kep
    - no one currently operating there, thus good time to work on this health issue
    - advised that the project director should meet with NCHADS director to ensure our position in yearly planning of HIV related activities
- Travel to RESCUE: NGO run by Marie Ens
  - spent afternoon with her, seeing physical site, meeting families, children
  - long discussion with medic that works with her, did some clinical rounds with him, and discussed treatment options for OIs

Saturday 14<sup>th</sup>:

- free day

Sunday 15<sup>th</sup>:

- free day
- bookkeeping

Week #3, February 16<sup>th</sup> – 22<sup>nd</sup>:

Monday 16<sup>th</sup>:

- Medicam: Medical NGO Library
  - obtaining immunization documents for Ian
- bank

Tuesday 17<sup>th</sup>:

- meeting at NCHP regarding CIH Immunization Initiative
  - handed over document, proposal, signature sheets
  - discussed project
  - explained need for input from counterparts, and the deadline
  - they advised that they would have their director sign and would fax the sheets on the 20<sup>th</sup>
- Medicam in afternoon

Wednesday 18<sup>th</sup>:

- Pharmacy
- Bank
- to Kep in afternoon

Thursday 19<sup>th</sup>:

- Clinic at Phnom Var:
  - 8:30am to noon—hut visits to sickest
  - 12:30pm to 3:00pm—ambulatory care clinic

Friday 20<sup>th</sup>:

- Clinic at Phnom Var:
  - 8:30am to noon—ambulatory care clinic
- bookkeeping

Saturday 21<sup>st</sup>:

- free day

Sunday 22<sup>nd</sup>:

- free day

Week #4, February 23<sup>rd</sup> to 29<sup>th</sup>:

- off
- February 26<sup>th</sup>—did bookings at Oasis and Veranda for Ann, Shiv, Ian, Ross
- February 28<sup>th</sup>, received email indicating I needed to return home for an interview in Montreal on March 13<sup>th</sup>

Week #5, March 1<sup>st</sup> to 7<sup>th</sup>:

Monday 1<sup>st</sup>:

- bank
- pharmacy
- Medicam

Tuesday 2<sup>nd</sup>:

- bank
- back to Kep
- meeting with Dr. Dinah at Referral Hospital regarding HIV in Kep
- worked on discussion paper

Wednesday 3<sup>rd</sup>:

- worked on discussion paper
- attended Lok Boe's son's wedding

Thursday 4<sup>th</sup>:

- Clinic at Phnom Var:
  - 8:30am to noon—hut visits to sickest
  - 12:30pm to 3:00pm—ambulatory care clinic

Friday 5<sup>th</sup>:

- Clinic at Phnom Var:
  - 8:30am to noon—ambulatory care clinic
- to PP in afternoon

Saturday 6<sup>th</sup>:

- worked on discussion paper
- picked up Ann and Shiv at airport
  - to computer store to set up their computer
  - pharmacy
  - began initial orientation over lunch and supper

Sunday 7<sup>th</sup>:

- orientation and handover to Ann and Shiv

Week #6, March 8<sup>th</sup> to 14<sup>th</sup>:

Monday 8<sup>th</sup>:

- visit to Phnom Var:
  - village meeting to say good-bye, thank you, and introduce Shiv and Ann
- visits to all three Health Centres, due to National Holiday, none were staffed
  - stopped in village near Pong Teuk and spoke with Director, introduced Ann and Shiv, they explained their goals re—primary health care, and maternal health issues
- meeting with Dr. Dinah at Referral Hospital
- to PP in early evening

Tuesday 9<sup>th</sup>:

- depart Cambodia

## APPENDIX 2

### *Terms of Reference*

Alenia Kysela

November 8, 2003 to April 2004

#### Main Objective:

This ToR represents the objectives of the first part of a two part fieldwork initiative. The associate will be working as a physician and anthropologist to collect both medical and ethnographic information regarding the people living in the 'HIV village' in Kep. This will include the assessment and treatment of common local infectious diseases, and other medical ailments. The aim is to provide the CIH with the groundwork on which further initiatives regarding the HIV positive population may be based, and the ToR for the second part of this branch of the project (Feb-April) will reflect the changing mandate and objectives as they become apparent and will be based on the findings of this ToR.

#### Main Activities:

- Obtain baseline medical information on each individual living with HIV in the HIV village, including basic assessments for co-morbid conditions and nutritional status
- Conduct key informant interviews, focus groups, and use participant observation to obtain ethnographic details relating to the following issues:
  - health seeking behaviour
  - perceptions of disease state
  - perceptions of traditional and western medicine (including ARV therapy)
  - perceptions of external international medical assistance
  - perceptions of long term consequences of disease state
  - perceived health needs: social, nutritional, medical or other
  - financial security
- Ongoing collaboration with local MoH health care workers vis a vis half day per week doing clinical work at Pong Teuk Health Centre, and time permitting, half day per week of clinical rounds at Kep Referral Hospital.
- Assist as required in other CIH programming requirements, including:
  - primary health care initiative
  - resident supervision
  - orientating other CIH associates who are incoming to the field
- Maintain weekly communication with the programme director
- Produce a final report which will include both the clinical and ethnographic information

